Form 026 2/08

State of Utah - Labor Commission

Division of Adjudication
160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800
laborcommission.utah.gov

Note: PLEASE TYPE OR PRINT IN BLACK INK

_____ Petitioner (Injured Worker) _____ Other name(s) used by petitioner (Injured Worker) **Vs.** _____ Respondent (Employer) _____ Respondent's mailing address _____ City, State and Zip Code _____ Respondent's phone number _____ Respondent's worker's compensation insurance carrier	**APPLICATION FOR HEARING** **Occupational Disease Claim** If you were employed for less than one year at your last employer where the injurious exposure occurred, you must file a separate Application for Hearing for each previous employer where you suffered an injurious exposure. (NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned.) I request to have a **Claims Resolution Conference** scheduled to resolve the issues checked below. ❒ **YES** ❒ **NO**

PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. I sustained an injury by injurious exposure arising out of and in the course of my employment with the above named employer, which injurious exposure occurred from Month _____ Date _____ Year_____ to Month _____ Date _____Year_____

2. The injurious exposure occurred at the following location:_____

3. The injurious exposure resulted from either the following repetitive work activities, or harmful substances:_____
   _____

4. The injuries I sustained from the accident are: _____
   _____

5. Petitioner's birth date: _____

6. At the time of the accident at issue my wage was $_____ per _____, and I was working _____ hours per week. I was ____was not _____ married and had _____dependent children.

APPLICATION FOR HEARING

7. I claim: (Please mark an "X" next to any issues you want resolved by hearing and attach relevant supporting documentation for each issue marked.

A. ❑ **Medical Expenses**: (specify the providers and amounts of unpaid medical expenses):_____
_____

B. ❑ **Recommended Medical Care**: (specify services or treatment):_____
_____

C. ❑ **Temporary Total Disability Compensation**: time off work from _____ to_____; from _____ to _____ from _____ to: _____.

D. ❑ **Temporary Partial Disability Compensation**: reduced wages from _____ to_____; from _____ to _____; from _____ to: _____.

E. ❑ **Permanent Partial Disability Compensation**: (specify impairment rating(s) for each injury: _____
_____

F. ❑ **Permanent Total Disability Compensation**: permanent inability to work. (Important - you must complete the Permanent Total Disability Fact Sheet for permanent total disability compensation claims.)

G. ❑ **Travel Expenses**. (If you claim reimbursement for travel expenses you must attach a separate sheet with the name of the medical provider, the date(s) of service, and the mileage to the provider for each date.)

H. ❑ **Unpaid Interest**.

I. ❑ **Other (specify)**:_____

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.

_____ Printed Name of Attorney for Petitioner State Bar #	_____ **Signature of Petitioner** Date
_____ Signature of Attorney for Petitioner	_____ Mailing Address of Petitioner
_____ Mailing Address for Attorney for Petitioner	_____ City/State/Zip Code
_____ City/State/Zip Code	(_____)_____ Petitioner's Telephone Number
(___)_____ Telephone Number	_____ Petitioner's Social Security Number
(___)_____ FAX E Mail Address	

DOCUMENTS THAT MUST BE FILED WITH APPLICATION FOR HEARING

***IMPORTANT*: Failure to include completed and signed forms with all requested supporting documentation will result in the Application for Hearing being returned for completion. If the returned Application for Hearing is not completed and refiled with the requested supporting documents within sixty (60) days, the Application for Hearing will be dismissed.**

1. Form 308A, "Medical Treatment Provider List." (If you need additional space to list all medical providers you may attach an additional sheet.)

2. Form 309A, "Authorization to Disclose, Release, Use Protected Health Information." (HIPAA Compliant.)

3. Form 113, "Summary of Medical Record." (Petitioner may submit other medical records that provide medical support for the claims of petitioner.)

4. Form 152, "Appointment of Counsel." (Only required if petitioner is represented by an attorney.)

5. **Permanent Total Disability Fact Sheet.** (Only required if the claim is for permanent total disability compensation.)

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim please include that information:

_____

Name of adjuster or third party administrator

_____

Mailing address for adjuster or third party administrator

_____

City/State/Zip Code

PERMANENT TOTAL DISABILITY FACT SHEET

You must complete this form if you are applying for permanent total disability compensation.

1. Date disability began: _____

2. Last Grade Completed in School: _____

3. Diplomas/Degrees/Licenses/or Specialized Training Completed by Petitioner: _____
   _____
   _____
   _____

4. Please state whether petitioner can speak and/or read and write in English: _____
   _____

5. Please identify any physical restrictions provided petitioner by a medical professional that prevent or hinder petitioner's return to employment: _____
   _____
   _____
   _____

6. Please identify any jobs petitioner has worked or applied for since the industrial injury at issue in the present case: _____
   _____
   _____
   _____

7. **Petitioner's Employment History:** (Attach additional sheets if necessary.)

Employer	Dates of Employment	Job Description